to pass the finest catheter beyond at least one, if not more, of the stones, and he injected a sterile solution. Whether because of this examination or a mere coincidence, the patient nevertheless passed all of the stones from the bladder and handed them to the expectant surgeon when about to operate two days after the ureteral catheterization.

DR. BREWER said it must not be assumed that every shadow disclosed by the X-ray in the region of the ureter was a stone. It had been shown by Leonard that certain small shadows in this region resulted from the presence of phlebolites or calcified lymph glands.

DR. LILIENTHAL said that in a case where the radiograph gave shadows that looked like stones, and the patient gave symptoms pointing to the presence of calculi, it was pretty safe to assume that we had to deal with calculi. In addition to the possible sources of error mentioned by Dr. Brewer, namely, phlebolites and calcified lymph nodes, there was one other that he had seen illustrated in a case of suspected ureteral calculus. The picture gave a shadow that bore a close resemblance to a calculus, but Mr. Caldwell, who took the X-ray, said he was convinced that it was not a stone, but a sesamoid bone, such as sometimes occurred in one of the obturator tendons.

SOME OBSERVATIONS ON PROSTATIC ABSCESS.

DR. SAMUEL ALEXANDER read a paper with the above title.

DR. BROWN said that, in his experience, prostatic abscess was comparatively rare. He could recall, perhaps, four or five cases, and in two of those rupture had already taken place into the ischiorectal fossa.

DR. LILIENTHAL said that, in opening a prostatic abscess, he could see no advantage in opening the urethra; this, on the contrary, was rather a disadvantage, unless one had to deal with an old chronic abscess, and a fistulous opening into the urethra, where it would be advisable to curette and drain. In an ordinary acute case of prostatic abscess he favored the old-fashioned way of going in directly through the perineum into the capsule of the prostate and draining. This method was rapid and safe, no traumatism was inflicted on the urethra, and it was not necessary to pass any sounds. The speaker said he saw no serious

objection to opening the capsule of the prostate: he had done this in quite a number of cases, and had never seen any harm result, and in those cases where the abscess was still intraprostatic the cure was particularly quick and thorough. The kind of incision made very little difference, excepting that the curved von Dittel incision gave better chances for drainage. Dr. Lilienthal said he had always carefully and studiously avoided opening the urethra in operating on these cases, on account of the possible danger of the formation of a permanent suppurating sac. Nowadays, no one would open such an abscess through the rectum.

Dr. Alexander, in closing, said the reason he did not like to open an abscess of the prostate through the capsule was because in all the cases upon which he had operated, as well as in those which he had seen in other hands, there was already, at the time of operation, an opening from the urethra into the abscess, or else such an opening occurred subsequently. In the vast majority of the cases the mucous membrane of the prostatic urethra was already so much diseased that an opening was unavoidable. Dr. Alexander said that the point at which he opened these abscesses was near the apex of the prostate, and in every instance he tried to make the floor of the abscess cavity absolutely flush with the floor of the urethra, and leave no pockets. The operation could usually be done within fifteen minutes. In some cases there was considerable hæmorrhage, necessitating the packing of the wound, but this was exceptional, as a rule, the hæmorrhage was no more than when the opening was made through the capsule. The disadvantage of opening through the capsule was, that if at the same time there was an opening into the urethra a permanent perineal fistula was more often the result. As to the frequency of prostatic abscess, the speaker thought the condition was common, but often existed without being recognized. During his absence from the hospital last summer, his associate, Dr. Edgerton, had operated on at least twenty cases.